

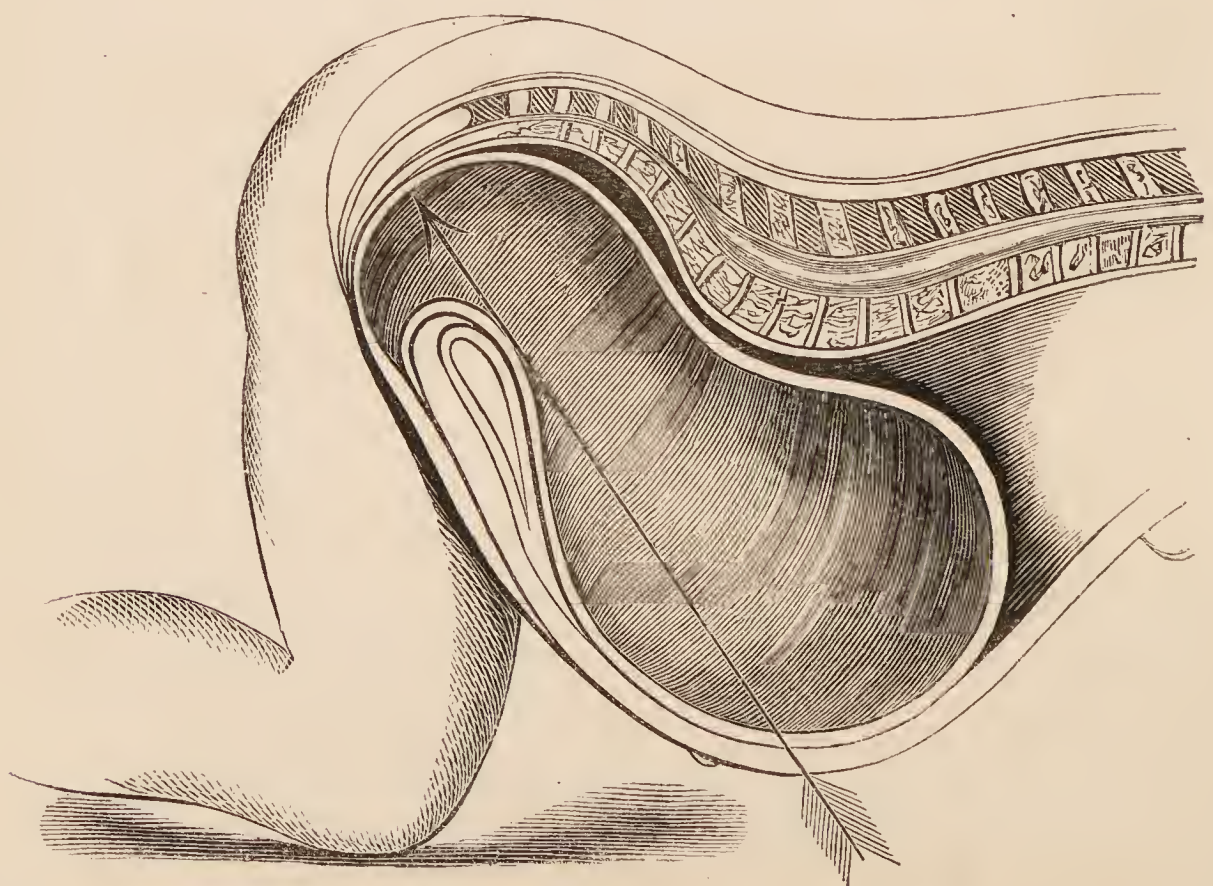
PROLAPSE OF THE CORD.

FIG. 1.



In Fig. 1. the arrow represents the direction of the uterine axis, which is forwards and downwards, the woman being on her back.

FIG. 2.



In Fig. 2. this axis is represented inverted by the change of position.

REMARKS
ON THE
POSTURAL TREATMENT
OF
PROLAPSE OF THE FUNIS.

WITH
CASES ILLUSTRATIVE OF ITS SUCCESSFUL EMPLOYMENT.

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OBSERVATIONS
ON
PROLAPSE OF THE UMBILICAL CORD,
AND ITS
REPLACEMENT BY THE "POSTURAL TREATMENT."

THERE are few complications occurring in the course of parturition, which to the accoucheur occasion more anxiety, and involve more trouble as regards management, than prolapse of the umbilical cord before or along with the presenting part of the child. Such a complication is one fraught with imminent peril to the infant, without endangering in the least degree the safety of the mother, or interfering in any way with the progress and duration of the labour. It is not my intention in the present communication to enter upon, far less to discuss, the various circumstances which have been assigned as likely to cause or to favour the occurrence of this complication. Prolapse of the cord is an accident fortunately of comparatively rare occurrence. According to the statistics of Dr. Churchill, out of 152,574 cases of labour, there were 699 examples of prolapsed funis, or about 1 in 218. Every one at all conversant with obstetric practice must, I think, unhesitatingly acknowledge that the usual methods of treating cases of this description are very far from being satisfactory. I presume that it is now generally admitted that the cases of prolapsus of the funis are few and rare in which the life of the infant is saved, when the labour is left to the unaided powers of nature. Although the accident is extremely simple, and the remedy perfectly obvious, the results of the ordinary modes of treating this complication are calculated to reflect in no small degree upon obstetric practice. A great variety of expedients have been from time to time suggested for the treatment of this complication, and an almost endless variety of instruments have been devised for the reduction or reposition of the prolapsed funis. The very circumstance of there being such a great variety of "remedies" may, I think, be safely regarded as an indication

that most, if not all of them, are imperfect and inefficient. Many of these means and contrivances are doubtless extremely ingenious, and seemingly easy and certain in their application, but in practice this is found unfortunately not to be the case. This, I think, is abundantly proved by the high rate of infantile mortality resulting from this complication. According to the statistical table compiled by Dr. Churchill, we find that out of 722 cases of prolapsed funis 375 children were lost, or more than one half—which is, it will be observed, a higher rate of mortality than in any other order of practicable labour. We must, however, in estimating the risks or calculating the results of this accident to the child, make some allowance for those cases where the cord is prolapsed and nearly or altogether pulseless before assistance was obtained. Such cases, for example, every now and then occur in Maternity Hospitals, where patients do not apply for admission till the chance of saving the child is diminished or entirely lost. But still this is hardly a justification for the great proportion of deaths that result from presentation or prolapse of the cord.

The great infantile mortality that attends this accident having been admitted, the question naturally suggests itself, Can nothing be done to reduce or diminish this mortality? I believe we are in possession of a mode of treatment which will, to a large degree, effect this most desirable object. The plan of treatment to which I allude is known as the "Postural" method, and was first described by Dr. Thomas, of New York, in 1858. The object of the present communication is briefly to call the attention of the profession to this mode of procedure, as I feel assured it is not so generally known as it deserves to be. Dr. Thomas recommends that the patient should be placed on her elbows and knees, so as to invert or reverse the inclined plane formed by the uterine cavity and the pelvis, and in this way secure the advantages which the influence of gravitation affords. If the membranes be still unruptured, it is quite possible that, with the woman in this position, the coil of the presenting funis may spontaneously slip over the head. Should the cord, however, have descended far into the vagina, it is to be carefully carried beyond the head with the fingers (the patient still retaining her position on the knees and elbows), till the supervention of a few pains, when it is quite probable the head will then have passed so low as fully to occupy the pelvic cavity, and thus preclude the likelihood of the cord again prolapsing. Dr. Thomas thus describes the history of the operation, and the manner in which it is performed:—"In a course of lectures," he says, "on obstetrics, delivered by me in the University Medical College of this city, about two years ago, I closely investigated this subject, and came to the following

conclusions:—*First*, That the causes of the persistence of this accident (whatever may at first have produced it) reduced themselves to two—the slippery nature of the displaced part, and the inclined plane offered it by the uterus, by which to roll out of its cavity; and, *Second*, That the only rational mode of treatment would be inverting this plane, and thus turning to our advantage not only it, but the lubricity of the cord, which ordinarily constitutes the main barrier to our success. This, I found, could be readily accomplished by *placing the woman on her knees, with the head down upon the bed*, in the posture assumed by eastern nations in worship, and now often resorted to in surgical operations upon the uterus and vagina. Let it be remembered that the axis of the uterus is a line running from the umbilicus, or a little above it, to the coccyx; and it will be seen that, by placing the woman in this position, it will be entirely inverted.”—(*Transactions of the New York Academy of Medicine*: vol. ii., part 2, p. 21).*

Such then is the postural method. It is an operation so simple and so safe, and “so in accordance with common sense,” that I believe it will commend itself to general adoption, and that it will ere long supplant and supersede all the modes of management commonly had recourse to in cases of descended cord. One of the great advantages of this method of treatment is that no instrument is required; the practice can be adopted and carried out at once and without delay. Dr. Ramsbotham, in speaking of the many mechanical means which have been invented for the restoration of the prolapsed cord, very truly remarks, that “it is impossible that we should be able to carry constantly with us any instrument only designed for the purpose under consideration; and, indeed, when we regard the rarity of this accident, to do so would appear absurd; on the other hand, the occurrence is likely to have compromised the child’s life before we could obtain an instrument from home.”† If we can adopt a method of treating such cases on the spur of the moment, a material and valuable point will be gained. This, I believe, by the postural method we may always do. I may mention that this method of treating prolapse of the funis has been successfully tried by several British and foreign obstetricians. In several cases which have occurred under my own observation, the result of the postural treatment was eminently satisfactory.

* The accompanying Plate, which is copied from Dr. Thomas’ paper, illustrates the principle of the practice better than any verbal description. It represents the axes and positions of the uterus (fig. 1), the patient being on her back; fig. 2, the patient being in the reversed position, upon her knees and elbows.

† *Obstetric Medicine and Surgery*, p. 515.

In the event of there being any obstacle or objection to placing the patient on her elbows and knees, it has been suggested that she should lie upon the side, corresponding to that on which the cord protrudes, taking care at the same time to have the breech well elevated; by this means the uterine plane is for the time being inverted or reversed, so that the cord tends to gravitate down towards the cavity or fundus.

Dr. Alexander R. Simpson, in his published notes of a very interesting and instructive case of prolapsus of the funis, treated by the postural method with a result in every respect most gratifying, puts the query, "Are not the differences which have been observed in the relative frequency with which prolapse of the cord occurs in France, England, and Germany, to be in some degree explained by the different positions in which parturient women are placed in these respective regions? In France, where, though the patient is laid on her back, the pelvis is kept elevated, the complication occurs, according to Dr. Churchill, only once in 373 cases; in Britain, where the patient is kept on her side, on a nearly level surface, it occurs in 1 in $210\frac{1}{3}$ cases; in Germany, where the patient is placed on the back, with the shoulders higher than the pelvis, it occurs as often as 1 in $162\frac{2}{3}$ cases." For my own part I have been long impressed with the belief, that the different obstetric positions in which women are placed in different countries during labour must exert some influence in the occurrence of this complication.

The following are the brief reports of two out of several cases in which I have successfully tried the postural method. I also append the notes of a case which have recently been transmitted to me by Dr. William L. Muir, one of my former students, in which this mode of management was advantageously resorted to.

CASE I.—July, 1864, Mrs. —, aged 33, multipara. Had been in labour three hours before my visit. On examination *per vaginam*, the os uteri was found dilated to about the size of a florin, and was somewhat relaxed and dilatable. The head was felt to present through the unruptured membranes. In about an hour after my arrival the liquor amnii was discharged. Upon now instituting a second vaginal examination I ascertained that a loop of the cord had descended by the side of the head. The umbilical vessels were pulsating vigorously. I at once attempted replacement of the cord by the fingers, and succeeded without much difficulty in pushing the cord up alongside the presenting head, beyond the influence of pressure; but only a few minutes elapsed when it was again in the vagina as before. Other two attempts were made, but with a similar result. Having no instrument at hand, and being unwilling to subject the patient to the dangers attendant upon podalic version, I forthwith resolved to test the

merits of the postural treatment. The patient having been placed upon her knees and elbows, *during the interval of pain*, I carried the displaced loop of cord cautiously down through the os uteri, when it glided away beyond the presenting head into the cavity of the uterus. Abdominal frictions and ergot were now had recourse to, with the desirable effect of increasing the uterine action. The patient was kept in the position above mentioned for about half an hour, at the expiry of which period, the head having fairly entered the pelvis, she was allowed to assume the usual obstetric position. There was fortunately no recurrence of the prolapse. In about three-quarters of an hour afterwards the child was born alive and vigorous.

CASE II.—June, 1865. The subject of this case was Mrs. —, aged 29 years—a pluripara. Had been in labour for upwards of two hours before my visiting her. The os uteri, on examination, was found unusually high up, and dilated to about the size of half-a-crown. The head was found to present, and by its side a coil of the cord about four inches long was prolapsed, and distinctly pulsating. The liquor amnii had escaped just as I entered the house. I attempted with the fingers several times to return the cord, but it was no sooner replaced *in utero* than it was forced down again by each recurring uterine contraction. I had now recourse to the postural treatment. The patient having been placed upon her elbows and knees, I gently pushed the cord through the os uteri during the absence of a pain. It appeared at once to slip away past the presenting head into the uterine cavity, quite beyond the reach of the fingers. Ergot, and friction over the abdomen, were now resorted to, with the view of stimulating the uterus to increased activity. As soon as the head came to occupy the pelvic cavity, which it did in about twenty minutes, the patient, as in the previous case, was permitted to resume the left lateral position. Labour terminated in little more than an hour afterwards without any subsequent descent of the funis. The child was born living and vigorous.

CASE III.—The following are the details of Dr. Muir's case already referred to.—“Mrs. C——, a well-formed pluripara, the present labour being her fifth, her former confinements having been, so far as I can learn, all uncomplicated. When first called at eleven o'clock on the evening of the 27th December, 1866, she had been in labour for seven or eight hours; the membranes had broken about fifteen minutes before my arrival, and since their rupture only two or three short trivial pains had been felt.

“On making an examination, I found a loop of the funis protruding externally, which pulsated feebly in the intervals of pain, but ceased to do so on the occurrence of a uterine contraction; the external passages soft, dilatable, and roomy; the os

uteri fully dilated; the head presenting with the occiput to the left sacro-iliac synchondrosis. After fully satisfying myself of the gravity of the case, I considered it proper to inform the friends that in all probability the child would be still-born. I now tried to return the cord with the woman lying in the ordinary position, but found it impossible, as no sooner had a portion of it been returned, than the first pain brought it all down again. The woman was now placed on her elbows and knees; my hand, well greased, was introduced into the vagina, and, during the intervals of pain, firm yet gentle pressure being applied to the head, it was disengaged from the pelvis back into the uterus. After some little manipulation I succeeded in pushing the cord beyond the child's head, and retained it there with my fingers until the uterus, which was now acting with great vigour, once more locked the head in the pelvic cavity: my hand was not withdrawn until all fear of a fresh prolapse of the funis had vanished. The woman resumed the ordinary obstetric position, after having been on her knees for one hour and a quarter; in two hours more she was safely delivered of a living though rather feeble female child—the placenta came away in about fifteen minutes. Mother and child have since both continued well."

It has been asserted that the postural method will not succeed when the waters have completely escaped, and the uterus is closely contracted upon the child. The cases just recorded, and those reported by Professor Dyce and others, entirely disprove this assertion. It is of great importance, I think, to bear in mind that the operation should be performed, *not during*, but in the *interval* of pain. In the event of any difficulty being experienced in returning the cord, whether it may proceed from passive or from active contraction of the uterus, the use of chloroform, as suggested by Professor Dyce, would greatly facilitate the operation, by its relaxing influence upon the uterus.

